EXECUTIVE SUMMARY
ARMY SUICIDE EVENT REPORT (ASER)
CALENDAR YEAR 2007

The Army Suicide Event Report (ASER) standardizes data collected on suicide events and is an integral part of the Army's Suicide Prevention Program. Completion of the ASER allows for detailed Army-wide statistical reports on suicide events.

Method:
The ASER is a surveillance tool and process to gather standardized risk and protective factor information for suicide events across multiple domains. Submission of an ASER is required for all suicide-related behaviors that result in death, hospitalization, or evacuation from theater. ASER points of contact (POCs) are designated by medical treatment facility (MTF) Commanders and are responsible for completion of ASERs. ASER POCs are also required to submit monthly reports on suicide-related hospitalizations.

Purpose:
ASER data comprise the only Army-wide repository for a spectrum of suicide behaviors and provide for a more detailed set of psychosocial and event information on completed suicides than is otherwise available. ASER analyses are frequently relied upon by the Army and DOD leadership. The ASER database, which includes 1666 records from this year alone, provides a meaningful tool for the AMEDD to leverage in support of suicide evaluation.
Conclusions are presently limited by the relatively small sample size when looking at individual risk factors and the unavailability of control group data. However, combining data across multiple years provided the opportunity to conduct deployment subgroup analyses. Future efforts will continue to pursue further advances for the program to enhance support to the AMEDD, the Army, and the DOD.

Summary of Results:
This annual report of the ASER provides statistics for CY 2007 as reported and submitted as of 1 March 2008. In 2007, there were 108 suicides confirmed by AFME at the time of this writing, including 29 in Iraq, 4 in Afghanistan, 0 in Kuwait. ASERs were received for 93% of all confirmed suicides. One-hundred-and-sixty-six suicide attempts were reported as occurring in OIF-OEF. Suicide behaviors were significantly more common for young, Caucasian, unmarried, junior enlisted Soldiers. Younger, lower-enlisted female Soldiers were overrepresented for suicide attempts compared to completions. Firearms were the most common method for completed suicide and overdoses and cutting were the most common methods for attempts. Thirty percent of suicide cases reportedly used drugs and/or alcohol during the event, and these rates were higher for suicide attempts. The majority of suicide cases did not have a known history of a mental disorder; 6% of suicide cases and 8% of cases with a suicide attempt reportedly had a prior diagnosis of PTSD. Fifty percent of Soldiers who completed suicide had a recent failed intimate relationship; similar results were observed among those with suicide attempts. Seven percent of completions and 7% of attempts had histories of multiple deployments to Iraq and/or Afghanistan reported. ASER data suggested a differential pattern of risk factors for suicide behaviors during OIF-OEF deployments compared to suicide behaviors in other settings. Marriage may be more protective against a completion and less protective against a suicide attempt during deployment compared to other event locations. Similar results were observed for having a minor child. Rates of work-related problems were generally higher among those with OIF-OEF events, while rates for a number of traditional stressors and risk factors (e.g. failed intimate relationships) were lower for Soldiers with suicides during deployment. In addition, there was a significant relationship between suicide attempts and number of days deployed to OIF-OEF, with the second quarter of deployment showing the highest frequency of attempts. Rates of traditional risk factors for suicide were similar between 2006 and 2007 Army suicides. Conclusions and interpretations regarding noted patterns must be made cautiously until data are available for a demographically similar comparison group of Army Soldiers.